MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF HOME CARE AND REHABILITATIVE STANDARDS

LETTER OF INTENT FOR STATE LICENSURE and/or MEDICARE CERTIFICATION

COMPLETE INFORMATION AND RETURN ALONG WITH POLICY MANUAL AND MEDICARE FORMS, IF APPLICABLE. MAIL TO: MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES, BUREAU OF HOME CARE AND REHABILITATIVE STANDARDS, P.O. BOX 570, JEFFERSON CITY, MO 65102.

NAME OF AGENCY	TELEPHONE NO.
ADDRESS (STREET, CITY, STATE, ZIP)	COUNTY
CONTACT PERSON	EMAIL ADDRESS

TYPE OF AGENCY

☐ HOME HEALTH AGENCY ☐ HOSPICE ☐ MEDICARE CERTIFICATION ☐ STATE LICENSURE

OWNERSHIP AND MANAGEMENT

☐ Hospital Based
☐ SNF/ICF Based Agency
☐ Rehabilitation Facility Based Agency
☐ Subunit
☐ Free Standing Agency
☐ Other
_____

Provider Base Entity:
_____
_____
Address: _____
_____
_____
Provider Number: _____
Fiscal Year Ending Date: _____

Non-Profit
☐ Corporation
☐ Other (Explain)
_____

Proprietary
☐ Individual
☐ Partnership
☐ Corporation
_____

Government
☐ State
☐ County
☐ City
☐ City-County
☐ District

GEOGRAPHIC AREA - A new agency may only serve counties that are contiguous with the county you are located in.

LIST COUNTY(IES).

SERVICES PROVIDED (Home Health Agencies Check Two or More -- Hospices Must Provide All Core Services)

☐ Skilled Nursing ☐ Occupational Therapy ☐ Other _____
☐ Physical Therapy ☐ Medical Social Services
☐ Speech Therapy ☐ Home Health Aide
List Direct Service (PT, ST or Nursing)_____

IFOR OFFICE USE ONLY

Initial Forms Received

☐ HHA-30 ☐ CMS-417 ☐ HHS-690 ☐ 855 Apprd: _____ ☐ SOS Registration
☐ CMS-1561 ☐ Lic. App ☐ Lic. Fee ☐ OASIS Transmission _____ ☐ FI Additional Info _____

Assigned Surveyor _____ Policy Manual Received _____ *Surveyor Checked Out Manual _____

1561 Copies to RO: _____ *Manual Approved: _____

*Administrator Qualifications Approved:_____ *Geographic Area Reviewed:_____

*Permission Given to Agency to Start Caseload and: _____ Confirmation Letter (90): _____
Complete OASIS Test Transmission

*Dates of Additional Contact: _____
_____
_____
_____
_____
_____

Agency Called Bureau - Ready for Survey: _____ *Initial Survey Date:_____